Naturopathic Intake Form
PERSONAL MEDICAL HISTORY

List any surgeries, hospitalizations, imaging (CT, MRI, EEG, EKG, etc.)	Date MM/YY

ALLERGIES

Do you have any allergies to medications?

[ ] Yes [ ] No If yes, list medication and reaction

Do you have any food or environmental allergies or sensitivities (ie, dairy, pollen, etc)?

[ ] Yes [ ] No [ ] unknown. If yes, list allergy and reaction

IMMUNIZATION HISTORY

[ ] Polio	[ ] Pertussis	[ ] Hepatitis A	[ ] Hepatitis B
[ ] HIB	[ ] Diphtheria	[ ] Chicken pox	[ ] Tuberculosis
[ ] Flu shot	Date ?		
[ ] Others			

CHILDHOOD ILLNESS: CIRCLE ANY THAT APPLY

Chicken Pox	Mononucleosis	Rubella	German Measles
Diphtheria	Strep Throat	Tuberculosis	Scarlet Fever

LIST RECENT PREVENTATIVE SCREENING TESTS:

Test (CBC, lipids, etc)	Date	Result
Sigmoidoscopy		Normal [ ] Abnormal [ ]
Colonoscopy		Normal [ ] Abnormal [ ]
Pap smear		Normal [ ] Abnormal [ ]
Mammogram		Normal [ ] Abnormal [ ]
Dexascan		Normal [ ] Abnormal [ ]
PSA (prostate)		Normal [ ] Abnormal [ ]
Other:		Normal [ ] Abnormal [ ]

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PERSONAL MEDICAL HISTORY
SOCIAL HISTORY

With whom do you live and for how long?

Do you have a religious or spiritual practice? [ ] Yes [ ] No

If yes, please explain:

Do you have any pets that live in the home with you? [ ] Yes [ ] No Describe:

How often do you take vacations?

Do you exercise? [ ] Yes [ ] No

If yes, what type(s): minutes/day & days/week

Are you satisfied with your sex life? [ ] Yes [ ] No

DIET

Do you follow a particular diet (ie, vegan, vegetarian, gluten-free, dairy-free, etc.)? [ ]Yes [ ] No

If yes, Please describe what you typically eat:

Breakfast

Lunch

Dinner

Snacks/desserts

Beverages: Please indicate the amount consumed per day and circle Cups or Ounces

Water	Cups	Ounces
Coffee	Cups	Ounces
Tea (Black, herbal, other)	Cups	Ounces
Soda	Cups	Ounces
Juice	Cups	Ounces
Other	Cups	Ounces

Do you have any concerns about your relationship to your body and/or food or exercise that you would like to talk about at some point? [ ] Yes [ ] No On the scale below please rate your satisfaction with your body. 1 is no satisfaction, 10 is 100% satisfaction.

1 2 3 4 5 6 7 8 9 10

Do you have an eating disorder or a history of eating disorder? [ ]Yes [ ]No

If yes, please describe

Do you have a history of yo-yo dieting? [ ] Yes [ ] No

Have you had large weight variances that were not due to a medical condition? [ ] Yes [ ] No

If yes, please describe

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Smoke Cigarettes: [ ] Never smoked [ ] Yes, in the past. Date quit: Years of use:
[ ] Yes, currently Packs per day:
Other tobacco use: [ ] Pipe/Cigar/Chew/Snuff Years of Use:
Tobacco exposure: [ ] Second-hand smoke Years of exposure:
Do you drink alcohol? [ ] Never [ ] Past [ ] Currently Number of drinks/wk:
Have you been treated for alcoholism? [ ] Yes [ ] No
Have you ever used recreational drugs? [ ] Yes [ ] No If yes, please explain

Answer or check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Age (at death)						
Cause of death						
Anemia						
Asthma						
Hay fever, Hives						
Cancer						
Diabetes						
Epilepsy						
Glaucoma						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Stroke						
Tuberculosis						
Other:						

REVIEW OF SYSTEMS

For the following please circle:

Y = Yes/Current issue N = No/Never had P = Past problem

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MENTAL/EMOTIONAL

Depression	Y	N	P
Mood Swings	Y	N	P
Anxiety/Nervousness	Y	N	P
Tension	Y	N	P
Memory Problems	Y	N	P
Poor Concentration	Y	N	P
Considered suicide	Y	N	P
Attempted suicide	Y	N	P

Other

SKIN

Rashes	Y	N	P
Itching	Y	N	P
Changes in skin color	Y	N	P
Acne/boils	Y	N	P
Eczema	Y	N	P
Lumps/bumps	Y	N	P
Hair Loss	Y	N	P

Other

HEAD

Headaches	Y	N	P
Head	Y	N	P
Injury	Y	N	P
Jaw issues or TMJ	Y	N	P

Other

NECK

Lumps in neck	Y	N	P
Swollen Glands	Y	N	P
Goiter	Y	N	P
Pain or Stiffness in neck	Y	N	P

Other

EYES

Impaired Vision	Y	N	P
Glasses or Contacts	Y	N	P
Eye Pain or strain	Y	N	P
Tearing or dryness	Y	N	P
Double Vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Color blindness	Y	N	P

Other

EARS

Impaired hearing	Y	N	P
Ringing in ears	Y	N	P
Earaches	Y	N	P
History of ear infections	Y	N	P

Other

NOSE, THROAT, MOUTH

Stuffy Nose	Y	N	P
Frequent Colds	Y	N	P
Frequent sore throats	Y	N	P
Sinusitis	Y	N	P
Hoarseness	Y	N	P
Sore Tongue or lips	Y	N	P
Gum Problems	Y	N	P
Tooth Problems	Y	N	P
Teeth grinding	Y	N	P

Other

RESPIRATORY

Cough	Y	N	P
Excess Sputum	Y	N	P
Coughing up Blood	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P

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RESPIRATORY CONT.

Bronchitis	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Pain with Breathing	Y	N	P
Shortness of Breath	Y	N	P
-Lying down?	Y	N	P
Tuberculosis	Y	N	P

Other

CARDIOVASCULAR

High Blood Pressure	Y	N	P
Heart Disease	Y	N	P
Angina	Y	N	P
Chest Pain	Y	N	P
Murmurs	Y	N	P
Rheumatic Fever	Y	N	P
Swelling in ankles	Y	N	P
Palpitations, Fluttering	Y	N	P

Other

PERIPHERAL VASCULAR

Deep Leg Pain	Y	N	P
Cold Hands and Feet	Y	N	P
Varicose Veins	Y	N	P
Thrombophlebitis	Y	N	P

Other

BLOOD

Anemia	Y	N	P
Easy Bleeding or Bruising	Y	N	P
Previous Blood Transfusion	Y	N	P

Other

GASTROINTESTINAL

Trouble Swallowing?	Y	N	P
Change in Thirst	Y	N	P
Change in Appetite	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Vomiting Blood	Y	N	P

Frequency of Bowel Movements:

Times Each Day

Is this a change?	Y	N	P
Blood in Stool	Y	N	P
Black stools	Y	N	P
Diarrhea	Y	N	P
Constipation	Y	N	P
Abdominal pain or cramps	Y	N	P
Heartburn	Y	N	P
Belching or passing gas	Y	N	P
Jaundice (yellow skin)	Y	N	P
Liver Disease	Y	N	P
Gall Bladder Disease	Y	N	P
Ulcer	Y	N	P
Hemorrhoids	Y	N	P

Other

URINARY

Pain on Urination	Y	N	P
Increased Frequency	Y	N	P
Frequency at Night	Y	N	P
Inability to hold urine	Y	N	P
Frequent infections	Y	N	P
Kidney Stones	Y	N	P

Other

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NEUROLOGIC

Fainting	Y	N	P
Vertigo or Dizziness	Y	N	P
Seizures	Y	N	P
Paralysis	Y	N	P
Muscle Weakness	Y	N	P
Numbness/Tingling	Y	N	P
Loss of Memory	Y	N	P
Loss of Balance	Y	N	P

Other

ENDOCRINE

Hypothyroid	Y	N	P
Heat/Cold Intolerance	Y	N	P
Excessive Thirst	Y	N	P
Excessive Hunger	Y	N	P
Fatigue	Y	N	P
Hyperthyroid	Y	N	P
Diabetes	Y	N	P
-Type 1 or 2?	1		2
Seasonal depression	Y	N	P

Other

MUSCULOSKELETAL

Joint Pain or Stiffness	Y	N	P
Arthritis	Y	N	P
Broken Bones	Y	N	P
Muscle Spasms	Y	N	P
Weakness	Y	N	P
Sciatica	Y	N	P

Other

IMMUNE

Reactions to vaccines	Y	N	P
Persistent swollen glands	Y	N	P
Slow wound healing	Y	N	P
Chronic fatigue	Y	N	P
Chronic infections	Y	N	P
Night sweats	Y	N	P

Other

BREASTS

Do you perform self-exams?	Y	N	P
Breast Lumps	Y	N	P
Pain or Tenderness	Y	N	P
Nipple discharge	Y	N	P

Other

FEMALE REPRODUCTIVE

Are you sexually active?	Y	N	P
Sexual orientation:			
Birth control?	Y	N	P
Type:			
Do you use it every time?	Y	N	
STI protection?	Y	N	
Type:			
Do you use it every time?	Y	N	
Regular partner(s)?	Y	N	
Age of first Menses			
Age of Last Menses (if menopausal):			
Date of last Pap smear:			
Abnormal Pap smear?	Y	N	
If yes, date:			
Duration of Menses:			DAYS
Length of Cycle:			DAYS
Regular Cycles	Y	N	P
Bleeding Between Periods	Y	N	P
Painful Menses	Y	N	P
Excessive/Heavy Flow	Y	N	P
PMS	Y	N	P
If so, what symptoms?			

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FEMALE REPRODUCTIVE CONTINUED

Pain with Intercourse	Y	N	P
Sexual Difficulties	Y	N	P
Difficulty Conceiving	Y	N	P
Number of Pregnancies:			
Number of Live Births:			
Number of Miscarriages:			
Number of Abortions:			
Menopausal Symptoms	Y	N	P
Vaginal odor	Y	N	P
Vaginal Discharge	Y	N	P
Endometriosis	Y	N	P
Ovarian Cysts	Y	N	P
Gonorrhea	Y	N	P
Chlamydia	Y	N	P
Genital	Y	N	P
Warts	Y	N	P
Herpes	Y	N	P
Syphilis	Y	N	P

Other

MALE REPRODUCTIVE

Are you sexually active?	Y	N	
Sexual orientation:			
Birth control?	Y	N	
Type:			
Do you use it every time?	Y	N	
STI protection?	Y	N	
Type:			
Do you use it every time?	Y	N	
Do you have regular partner(s)?	Y	N	
Hernias	Y	N	P
Testicular Masses	Y	N	P
Testicular Pain	Y	N	P
Penile Discharge or Sores	Y	N	P
Gonorrhea	Y	N	P
Chlamydia	Y	N	P
Genital Warts	Y	N	P
Herpes	Y	N	P
Syphilis	Y	N	P
Prostate Disease	Y	N	P
What Type?			
Impotence	Y	N	P
Premature Ejaculation	Y	N	P

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